

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-3753.M5**

MDR Tracking Number: M5-04-2913-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 5-6-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 4-28-03 through 5-5-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that joint mobilization, myofascial release, supplies & materials, therapeutic exercise & activities, gait training, neuromuscular re-education, manual traction, chiropractic manipulation, neuromuscular stimulation, manual therapy-tech, durable medical equipment from 5-9-03 through 9-15-03 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Per a letter dated 12-16-04 the requestor has withdrawn the medical fee dispute.

This Finding and Decision is hereby issued this 17<sup>th</sup> of December 2004.

Donna Auby

Medical Dispute Resolution Officer  
Medical Review Division

August 3, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

**REVISED REPORT**  
**Initial report of 07/29/04 factually incorrect.**

Re: Medical Dispute Resolution  
MDR #: M5-04-2913-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.:

Dear

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

**REVIEWER'S REPORT**

**Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: correspondence, office notes, chiropractic notes, operative reports, electro-diagnostic and radiology reports.

Information provided by Respondent: correspondence and designated doctor report.

Information provided by Surgeon: office notes and operative report.

**Clinical History:**

This female patient injured her low back and left ankle while performing work duties and functions on the date of \_\_\_\_\_. She reported experiencing significant left ankle pain and low back pain with radiation into the left leg and foot. She was taken to the emergency room where she had extensive diagnostic testing and treatment program. Her treatment included medications, physical therapy, chiropractic care, injections, surgical intervention, and postoperative rehab.

**Disputed Services:**

Joint mobilization, myofascial release, supplies & materials, therapeutic exercise & activities, gait training, neuromuscular re-education, manual traction, chiropractic manipulation, neuromuscular stimulation, manual therapy-tech, durable medical equipment from 05/09/03 thru 09/15/03.

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

**Rationale:**

National treatment guidelines allow for this type of treatment for this type of injury. However, they do not allow for the frequency, intensity, and extensive duration of treatment this patient has received. The records indicate the patient had an IDET procedure performed on 03/07/03. Prior to this procedure, the patient had undergone 65 physical therapy sessions since her date of injury. By 05/09/03, the first date of service after the dispute, the claimant had completed 28 sessions of postoperative therapy. The patient underwent a left ankle arthroscopy on 8/13/03. Postoperative rehab was done on 8/15/03. The records indicate the carrier paid for 15 sessions of postoperative rehab through 09/05/04. A neuromuscular stimulator was provided to the claimant by another healthcare provider, and the carrier has declined payment for another unit and supplies for the existing unit.

In conclusion, joint mobilization, myofascial release, supplies and materials, therapeutic exercises, gait training, therapeutic activities, neuromuscular reeducation, manual traction, chiropractic manipulation, neuromuscular stimulation, manual therapy-tech, and durable medical equipment from 05/09/03 through 09/15/03 were not reasonable, usual, customary, or medically necessary for the treatment of this patient's on the job injury dated \_\_\_\_\_.

Sincerely,